TRAFFIC LIGHT SYSTEM

FOR THE REFERRAL OF PATIENTS WITH SUSPECTED CARDIAC ARRHYTHMIA, CARDIAC SYNCOPE, OR FAMILY HISTORY OF SUDDEN DEATH IN THE UNDER 35s

NHS
South East London Cardiac Network

HISTORY, EXAMINATION, ECG (1)

Presentation	ECG / findings	Action
Acutely unwell with palpitations (1)		Urgent direct referral to Accident & Emergency
2°/3° Heart block Exercise induced syncope Syncope with injury Angina with syncope Syncope with known structural heart disease (2)	Usually abnormal ECG (1)	Urgent direct referral to Cardiologist or Arrhythmia specialist facilitated by Arrhythmia Care Co-ordinator
Atrial Fibrillation (3)		NICE guidance (± discuss with Arrhythmia Care Co-ordinator)
Recurrent palpitations Recurrent presyncope/syncope Symptomatic bradycardia Family history of sudden death or inherited cardiac condition (4)	± abnormal ECG ± structural heart disease	Referral to Cardiology Clinic/ Arrhythmia Care Co-ordinator
Transient palpitations Clear evidence of vasovagal symptoms (5)	Normal ECG No evidence of structural disease	Reassure Usually no need to refer (6) Contact Arrhythmia Care Co-ordinator if referral required

NOTES FOR TRAFFIC LIGHTS SYSTEM

THE SYSTEM IS INTENDED AS A GUIDE ONLY.
IT IS NOT EXHAUSTIVE AND NATURALLY CLINICAL JUDGEMENT SHOULD BE USED.

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(1) Please always include a copy of the ECG in the referral, unless the patient is acutely unwell in which case an ECG is not required. Abnormal ECG could include: Evidence of previous myocardial infarction or left ventricular hypertrophy, significant T wave inversion, left bundle branch block, Pre-excitation (Wolff-Parkinson-White syndrome), QTc interval prolongation (>460ms).

(2) History of structural heart disease might include history of myocardial infarction, cardiomyopathy, valvular heart disease, cardiac failure, or left ventricular hypertrophy.

(3) In cases of previously unknown atrial fibrillation consult NICE AF guidelines (June 2006). Consider anticoagulation; particularly if > 65 years age, or with previous hypertension, diabetes, ischaemic heart disease, thyrotoxicosis, valvular heart disease, or cardiac failure. If in doubt consider discussing with Arrhythmia Care Co-ordinator or Cardiologist prior to referral. Consider whether the patient should be anticoagulated prior to referral.

(4) In cases of sudden cardiac death in those under 35yrs, screening of family members is indicated. Consider referral to Network genetic arrhythmia clinic or similar specialist service. Liaison with the Arrhythmia Care Co-ordinator is recommended.

(5) The presence of clear evidence of vasovagal symptoms is suggested by young age, recurrent symptoms particularly with a known precipitant: e.g. cough, micturition, anxiety or crowded hot spaces. If in doubt consider cardiology referral.

(6) In patients designated as "Green" there should be a normal ECG and no known evidence of structural heart disease. If symptoms are persistent, or patients require further reassurance, consider referring to the Arrhythmia Care Co-ordinator.